SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

Filing at a Glance

Company: Atlantic Specialty Insurance Company

Product Name: Occupational Accident	SERFF Tr Num: CLTR-127649230	State: Arkansas
TOI: H02G Group Health - Accident Only	SERFF Status: Closed-Approved-Closed	State Tr Num: 49895
Sub-TOI: H02G.000 Health - Accident Only	Co Tr Num: AH 422A OAICT AR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Stephanie Young, Linda Ryan-James, Mark Swercheck, Wendy Hicks, Dana Suter	Disposition Date: 10/04/2011
	Date Submitted: 09/27/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Occupational Accident ICT	Status of Filing in Domicile:
Project Number: AH 422A OAICT	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Discretionary, Trust	Overall Rate Impact:
Filing Status Changed: 10/04/2011	
State Status Changed: 10/04/2011	Deemer Date:
Created By: Dana Suter	Submitted By: Wendy Hicks

Corresponding Filing Tracking Number: CLTR-125719051

Filing Description:

On behalf of Atlantic Specialty Insurance Company, Coulter and Associates is filing the attached Independent Contractor Trust forms/rates.

These forms were previously filed and approved for OneBeacon America Insurance Company and the only changes to the forms are the company name, form number and edition date.

These forms were approved for OneBeacon America Insurance Company on July 9, 2008 in SERFF Tracking Number

SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

CLTR-125719051. The forms will become effective upon approval.

If you have any questions, please call me at (609) 443-7540 or email me at stephaniey@coulter-and-associates.com. Otherwise we look forward to your approval.

Company and Contact

Filing Contact Information

Stephanie Young, Consultant	stephaniey@coulter-and-associates.com
C/O Coulter-and-associates.com	609-443-7540 [Phone]
379 Princeton-Hightstown Rd	609-443-4103 [FAX]
Suite 15	
Cranbury, NJ 08512	

Filing Company Information

(This filing was made by a third party - coulterandassociatesinc)

Atlantic Specialty Insurance Company	CoCode: 27154	State of Domicile: New York
One Beacon Lane	Group Code:	Company Type:
Canton, MA 02021	Group Name:	State ID Number:
(212) 428-6580 ext. [Phone]	FEIN Number: 13-3362309	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	3 X $50 = $150.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Atlantic Specialty Insurance Company	$150.00	09/27/2011	52180198

SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/04/2011	10/04/2011

SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

Disposition

Disposition Date: 10/04/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization to File	Approved-Closed	Yes
Supporting Document	Certification Rule 19	Approved-Closed	Yes
Form	Occupational Accident Certificate of Insurance	Approved-Closed	Yes
Form	Application/Enrollment Form Plans A B C	Approved-Closed	Yes
Form	Application Enrollment Form Plans 1 2 3	Approved-Closed	Yes

SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

Form Schedule

Lead Form Number: AH 422A OAICT 08 11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/04/2011	AH 422A OAICT 08 11	Certificate	Occupational Accident Certificate of Insurance	Initial			ASIC 422A Arkansas Certificate.pdf
Approved-Closed 10/04/2011	AH 428AA OAICT 08 11	Application/ Enrollment Form	Application/Enrollment Form Plans A B C	Initial			ASIC 428AA Arkansas Independent Contractor Trust Enrollment Form Plans A B C.pdf
Approved-Closed 10/04/2011	AH 429AA OAICT 08 11	Application/ Enrollment Form	Application Enrollment Form Plans 1 2 3	Initial			ASIC 429AA Arkansas Independent Contractor Trust Enrollment Form Plans 1 2 3.pdf

OCCUPATIONAL ACCIDENT

CERTIFICATE OF INSURANCE

FOR

CHRISTIANA BANK & TRUST COMPANY AS TRUSTEE FOR THE INDEPENDENT CONTRACTOR TRUST

IMPORTANT NOTICE

THIS INSURANCE IS NOT WORKERS' COMPENSATION INSURANCE.

IT IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION INSURANCE.

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

AND IT DOES NOT COVER ANY PERSON WHO IS REQUIRED TO BE COVERED BY A WORKERS' COMPENSATION POLICY

Atlantic Specialty Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: **Christiana Bank & Trust Company**
as Trustee for the Independent Contractor Trust

POLICY NUMBER: **216-000-087**

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

OCCUPATIONAL ACCIDENT

CERTIFICATE OF INSURANCE

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBLILTY

You are eligible to become an **Insured Person** provided **You** are at least twenty-three (23) years of age, under **Dispatch** an average of thirty (30) hours each week (i.e. **Actively at Work**), have completed enrollment material on file with the **Policyholder**, if required, and **You** are:

Class I:

An **Actively at Work Owner-Operator** who is enrolled for coverage under the **Policy** and agrees to participate in the **Trust**. For purposes of the **Policy**, an **Owner-Operator** must:

1. have a valid and current Commercial Driver's License;
2. own or lease a power unit;
3. be responsible for the maintenance of the power unit;
4. be responsible for the operating costs of the power unit, including but not limited to fuel, repairs, supplies and other expenses associated with the operation of the power unit;
5. be responsible for maintaining physical damage insurance on the power unit;
6. be responsible for hiring and supervising personnel who operate the power unit;
7. be compensated on a basis other than time expended in the performance of work;
8. be responsible for determining the route and hours for an assignment;
9. have the right to select the load;
10. have a written contract or assignment from the person who has engaged his or her services which provides that he or she is an independent contractor;
11. be classified as an independent contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose; and
12. receive a 1099 form for federal income tax reporting purposes, not a W-2.

Class II:

An **Actively at Work Contract Driver** who is enrolled for coverage under the **Policy** and agrees to participate in the **Trust**. For purposes of the **Policy**, a **Contract Driver** must:

1. have a valid and current Commercial Driver's License;
2. be authorized by an **Owner-Operator** or motor carrier to operate a power unit owned or leased by an **Owner-Operator**. (The **Contract Driver** must neither own nor lease the power unit.);
3. be compensated on a basis other than time expended in the performance of work;
4. be responsible for determining the route and hours for an assignment;
5. operate the power unit of the person who has engaged his or her services as an independent contractor. (Operating the unit must be the principal duty of the **Contract Driver**.)
6. be classified as an independent contractor by the person who has engaged his or her services and not as an employee for purposes of workers' compensation insurance, federal income taxes, state income taxes, social security, unemployment insurance or for any other purpose;
7. receive a 1099 form for federal income tax reporting purposes, not a W-2; and
8. not be an employee of the **Owner-Operator**.

Class III:

An **Actively at Work Employee Driver** who is enrolled for coverage under the **Policy** and agrees to participate in the **Trust.** For purposes of the **Policy**, an **Employee Driver** must:

1. have a valid and current Commercial Driver's License;
2. be authorized by an **Owner-Operator** or motor carrier to operate a power unit;
3. neither own nor lease the power unit;

4. receive a W-2 for federal income tax purposes; and
5. be exempt from Workers' Compensation coverage. **The Employee Driver must have a completed and signed Certificate of Workers' Compensation Exemption on file with the Program Administrator.**

You cannot be covered by any other **Occupational Accident Policy** issued by **Us**.

If **You** pay premium but are not eligible for coverage or do not qualify for benefits under the **Policy**, **We** will refund any premium paid in error.

YOUR COVERAGE EFFECTIVE DATE

Class I-Owner-Operator: If **You** are an **Owner-Operator**, **Your** coverage under the **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above; or
3. the date upon which the **Program Administrator** approves **Your** fully completed and signed enrollment form.

Class II-Contract Driver: If **You** are a **Contract Driver**, **Your** coverage under the **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above; or
3. the date upon which the **Program Administrator** approves **Your** fully completed and signed enrollment form.

Class III-Employee Driver: If **You** are an **Employee Driver**, **Your** coverage under the **Policy** begins on the latest of:

1. the **Policy** Effective Date;
2. the date **You** become a member of an eligible Class as described above; or
3. the date upon which the **Program Administrator** approves **Your** fully completed and signed enrollment form

If the initial premium is not paid to the **Program Administrator** as of the premium due date, coverage will not be in effect.

YOUR TERMINATION DATE

Class I-Owner-Operator: If **You** are an **Owner-Operator**, **Your** coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;
2. if **You** are not using Premium Financing, the premium due date, if premiums are not paid when due, subject to the Grace Period. (The Grace Period does not apply to the initial premium due date.);
3. if **You** are using Premium Financing, the date **Your Attorney-in-Fact*** requests in writing, to the **Program Administrator**, that **Your** coverage be cancelled;
4. the date **You** request, in writing, to the **Program Administrator**, that **Your** coverage be terminated; or
5. the date **You** cease to be a member of an eligible Class as described above.

Class II-Contract Driver: If **You** are a **Contract Driver**, **Your** coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;
2. if **You** are not using Premium Financing, the premium due date, if premiums are not paid when due, subject to the Grace Period. (The Grace Period does not apply to the initial premium due date.);
3. if **You** are using Premium Financing, the date **Your Attorney-in-Fact*** requests in writing, to the **Program Administrator**, that **Your** coverage be cancelled;
4. the date **You** request, in writing, to the **Program Administrator**, that **Your** coverage be terminated;
5. the date **You** cease to be a member of an eligible Class as described above; or
6. the date the **Owner-Operator**, with respect to whom **You** are under contract, ceases to be a member of an eligible Class as described above.

Class III-Employee Driver: If **You** are an **Employee Driver**, **Your** coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;

2. if **You** are not using Premium Financing, the premium due date, if premiums are not paid when due, subject to the Grace Period. (The Grace Period does not apply to the initial premium due date.);

3. if **You** are using Premium Financing, the date **Your Attorney-in-Fact*** requests in writing, to the **Program Administrator**, that **Your** coverage be cancelled;

4. the date **You** request, in writing, to the **Program Administrator**, that **Your** coverage be terminated; or

5. the date **You** cease to be a member of an eligible Class as described above.

***** The **Attorney-in-Fact** is the person who is so designated in accordance with the terms of the Premium Finance Agreement with respect to this insurance coverage. **You** grant the **Attorney-in-Fact** the authority to effect cancellation of **Your** coverage under the **Policy**. The **Program Administrator** shall be entitled to abide by the instructions of the **Attorney-in-Fact** and shall be held harmless for acting in accordance with the instructions or notice of the **Attorney-in-Fact**. The **Attorney-in-Fact** shall have the right to receive a refund for any unearned premium as a result of the cancellation.

A change in **Your** coverage under the **Policy**, due to a change in **Your** eligible Class or benefit selection, becomes effective on the later of: (1) the date the change in **Your** eligible Class or benefit selection occurs; or (2) if the change requires a change in premium, the date the first changed premium is paid. However, a change in coverage applies only with respect to **Covered Accidents** that occur after the change becomes effective.

Subject to the terms, conditions, exclusions and limitations of the **Policy**, termination of coverage will not affect a claim for a **Covered Loss** that occurs either before or after such termination, if that **Covered Loss** results from an **Accident** that occurred while **Your** coverage was in force under the **Policy**.

SECTION II – SCHEDULE OF BENEFITS

PLAN A

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum *** $50,000
- **Accident Commencement Period** ..... 365 days

Survivor's Benefit:
- **Principal Sum *** $200,000
- Monthly Benefit Amount $2,000

Accidental Dismemberment Benefit:
- % of **Principal Sum** of * $250,000
- **Accident Commencement Period** ..... 365 days

Paralysis Benefit:
- **Principal Sum *** $250,000
- **Accident Commencement Period** ..... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** ..... 90 days
- **Waiting Period** ..... 7 days
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $500
- **Maximum Benefit Period **** ..... 104 weeks
- **Maximum Benefit Period** for Hernia ..... 10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** ..... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $500
- **Maximum Benefit Amount** $400,000
- **Maximum Benefit Period** ..... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** ..... 90 days
- **Deductible Amount** $0
- **Maximum Benefit Period** ..... 104 weeks
- Dental Maximum ..... $1,000 per **Accident**
- **Maximum Benefit Amount** per **Accident** $1,000,000
- Lifetime **Maximum Benefit** $1,000,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $1,000 per **Injury**
- Ambulance ..... one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance ..... one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- Hernia Coverage ..... lifetime **Maximum Benefit** of $10,000
- **Mental and Nervous –** Outpatient ..... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient ..... maximum $1,000 for any one **Accident**

Occupational Accident Limits of Liability

- **Combined Single Limit** $1,000,000
- **Aggregate Limit of Liability** $2,000,000
  (Applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum *.....$10,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
% of **Principal Sum** of *.....$10,000
Accident Commencement Period…….…..…....365 days

Accident Medical Expense Benefit:
Medical Commencement Period..... 90 days
Deductible Amount $0
Maximum Benefit Period.....52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**.....$5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy……..….$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$1,000 per **Injury**
- Ambulance……..……one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- **Mental and Nervous –** Outpatient……..……...……..... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient……maximum $1,000 for any one **Accident**

Non-Occupational Accident Limits of Liability

- **Combined Single Limit**.....$10,000
- **Aggregate Limit of Liability**……$20,000
  (Applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident**)

*At age 65, **Your Principal Sum** shall be based on the following schedule**:**

Age at Date of Loss	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** shall be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

PLAN B

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum *** $25,000
- **Accident Commencement Period** ..... 365 days

Survivor's Benefit:
- **Principal Sum *** $125,000
- Monthly Benefit Amount $1,250

Accidental Dismemberment Benefit:
- **Principal Sum *** $150,000
- **Accident Commencement Period** ..... 365 days

Paralysis Benefit:
- **Principal Sum *** $150,000
- **Accident Commencement Period** ..... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** ..... 90 days
- **Waiting Period** ..... 7 days
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Period **** ..... 52 weeks
- **Maximum Benefit Period** for Hernia ..... 10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** ..... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Amount** $300,000
- **Maximum Benefit Period** ..... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** ..... 90 days
- **Deductible Amount** $0
- **Maximum Benefit Period** ..... 52 weeks
- Dental Maximum ..... $1,000 per **Accident**
- **Maximum Benefit Amount** per **Accident** $500,000
- Lifetime **Maximum Benefit** $500,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $1,000 per **Injury**
- Ambulance ..... one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance ..... one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- Hernia Coverage ..... lifetime **Maximum Benefit** of $10,000
- **Mental and Nervous –** Outpatient ..... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient ..... maximum $1,000 for any one **Accident**

Occupational Accident Limits of Liability

- **Combined Single Limit** $500,000
- **Aggregate Limit of Liability** $1,000,000
  (Applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum * .....….$10,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
Principal Sum *.. .....$10,000
Accident Commencement Period…….…..…...365 days

Accident Medical Expense Benefit:
Medical Commencement Period ..... 90 days
Deductible Amount $0
Maximum Benefit Period.....52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**.....$5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$1,000 per **Injury**
- Ambulance……..……one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- **Mental and Nervous –** Outpatient……..……...……... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient……maximum $1,000 for any one **Accident**

Non-Occupational Accident Limits of Liability

- **Combined Single Limit**.....$10,000
- **Aggregate Limit of Liability**……...$20,000
  (Applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident)**

*At age 65, **Your Principal Sum** shall be based on the following schedule**:**

Age at Date of Loss	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** shall be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

[PLAN C

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum ***.....$25,000
- **Accident Commencement Period**.....365 days

Survivor's Benefit:
- **Principal Sum ***.....$125,000
- Monthly Benefit Amount.....$1,250

Accidental Dismemberment Benefit:
- **Principal Sum ***.....$150,000
- **Accident Commencement Period**.....365 days

Paralysis Benefit:
- **Principal Sum ***.....$150,000
- **Accident Commencement Period**.....365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period**.....90 days
- **Waiting Period**.....7 days
- Benefit Percentage.....70%
- **Minimum Weekly Benefit Amount**.....$125
- **Maximum Weekly Benefit Amount**.....$400
- **Maximum Benefit Period ****.....52 weeks
- **Maximum Benefit Period** for Hernia……...….10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** .....**Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage.....70%
- **Minimum Weekly Benefit Amount**.....$50
- **Maximum Weekly Benefit Amount**.....$400
- **Maximum Benefit Amount**.....$200,000
- **Maximum Benefit Period**.....to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period**.....90 days
- **Deductible Amount**.....$0
- **Maximum Benefit Period**.....52 weeks
- Dental Maximum.....$1,000 per **Accident**
- **Maximum Benefit Amount** per **Accident**.....$300,000
- Lifetime **Maximum Benefit**.....$300,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy…… .....$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….……...…..$1,000 per **Injury**
- Ambulance ……..…..…….one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance……..…….…….…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- Hernia Coverage…….....lifetime **Maximum Benefit** of $10,000
- **Mental and Nervous –** Outpatient…….....….... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient……..…..maximum $1,000 for any one **Accident**

Occupational Accident Limits of Liability

- **Combined Single Limit** $300,000
- **Aggregate Limit of Liability** $600,000
  (Applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum * .....…$10,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
Principal Sum *.. .....$10,000
Accident Commencement Period……...….....365 days

Accident Medical Expense Benefit:
Medical Commencement Period ..... 90 days
Deductible Amount $0
Maximum Benefit Period.....52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**.....$5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:

- Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$1,000 per **Injury**
- Ambulance……..……one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- **Mental and Nervous –** Outpatient……..……...…….... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient…….maximum $1,000 for any one **Accident**

Non-Occupational Accident Limits of Liability

- **Combined Single Limit** $10,000
- **Aggregate Limit of Liability**……...$20,000
  (Applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident)**

*At age 65, **Your Principal Sum** shall be based on the following schedule**:**

Age at Date of Loss	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** shall be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.]

PLAN 1

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum *** $50,000
- **Accident Commencement Period** ..... 365 days

Survivor's Benefit:
- **Principal Sum *** $200,000
- Monthly Benefit Amount $2,000

Accidental Dismemberment Benefit:
- % of **Principal Sum** of * $250,000
- **Accident Commencement Period** ..... 365 days

Paralysis Benefit:
- **Principal Sum *** $250,000
- **Accident Commencement Period** ..... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** ..... 90 days
- **Waiting Period** ..... 7 days
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $500
- **Maximum Benefit Period **** ..... 104 weeks
- **Maximum Benefit Period** for Hernia ..... 10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** ..... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $500
- **Maximum Benefit Amount** $400,000
- **Maximum Benefit Period** ..... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** ..... 90 days
- **Deductible Amount** $0
- **Maximum Benefit Period** ..... 104 weeks
- Dental Maximum ..... $1,000 per **Accident**
- **Maximum Benefit Amount** per **Accident** $1,000,000
- Lifetime **Maximum Benefit** $1,000,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $1,000 per **Injury**
- Ambulance ..... one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance ..... one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- Hernia Coverage ..... lifetime **Maximum Benefit** of $10,000
- **Mental and Nervous –** Outpatient ..... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient ..... maximum $1,000 for any one **Accident**

Occupational Accident Limits of Liability

- **Combined Single Limit** $1,000,000
- **Aggregate Limit of Liability** $2,000,000
  (Applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum *.....$15,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
% of **Principal Sum** of * $15,000
Accident Commencement Period……..…....365 days

Accident Medical Expense Benefit:
Medical Commencement Period ..... 90 days
Deductible Amount $0
Maximum Benefit Period.....52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**.....$5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy……..….$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….…....$1,000 per **Injury**
- Ambulance……..……one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- **Mental and Nervous –** Outpatient……..……...……... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient……maximum $1,000 for any one **Accident**

Non-Occupational Accident Limits of Liability

- **Combined Single Limit** $15,000
- **Aggregate Limit of Liability**……$30,000
  (Applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident**)

*At age 65, **Your Principal Sum** shall be based on the following schedule**:**

Age at Date of Loss	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** shall be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

PLAN 2

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum *** $25,000
- **Accident Commencement Period** ..... 365 days

Survivor's Benefit:
- **Principal Sum *** $125,000
- Monthly Benefit Amount $1,250

Accidental Dismemberment Benefit:
- **Principal Sum *** $150,000
- **Accident Commencement Period** ..... 365 days

Paralysis Benefit:
- **Principal Sum *** $150,000
- **Accident Commencement Period** ..... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** ..... 90 days
- **Waiting Period** ..... 7 days
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Period **** ..... 52 weeks
- **Maximum Benefit Period** for Hernia ..... 10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** ..... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Amount** $300,000
- **Maximum Benefit Period** ..... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** ..... 90 days
- **Deductible Amount** $0
- **Maximum Benefit Period** ..... 52 weeks
- Dental Maximum ..... $1,000 per **Accident**
- **Maximum Benefit Amount** per **Accident** $500,000
- Lifetime **Maximum Benefit** $500,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy ..... $1,000 per **Injury**
- Ambulance ..... one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance ..... one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- Hernia Coverage ..... lifetime **Maximum Benefit** of $10,000
- **Mental and Nervous –** Outpatient ..... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient ..... maximum $1,000 for any one **Accident**

Occupational Accident Limits of Liability

- **Combined Single Limit** $500,000
- **Aggregate Limit of Liability** $1,000,000
  (Applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum * .....….$15,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
Principal Sum *.. .....$15,000
Accident Commencement Period…….…..…...365 days

Accident Medical Expense Benefit:
Medical Commencement Period ..... 90 days
Deductible Amount $0
Maximum Benefit Period.....52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**.....$5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$1,000 per **Injury**
- Ambulance……..……one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- **Mental and Nervous –** Outpatient……..……...……... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient……maximum $1,000 for any one **Accident**

Non-Occupational Accident Limits of Liability

- **Combined Single Limit** $15,000
- **Aggregate Limit of Liability**……...$30,000
  (Applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident)**

*At age 65, **Your Principal Sum** shall be based on the following schedule**:**

Age at Date of Loss	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** shall be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.

[PLAN 3

OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
- **Principal Sum *** $25,000
- **Accident Commencement Period** ..... 365 days

Survivor's Benefit:
- **Principal Sum *** $125,000
- Monthly Benefit Amount $1,250

Accidental Dismemberment Benefit:
- **Principal Sum *** $150,000
- **Accident Commencement Period** ..... 365 days

Paralysis Benefit:
- **Principal Sum *** $150,000
- **Accident Commencement Period** ..... 365 days

Temporary Total Disability Benefit:
- **Disability Commencement Period** ..... 90 days
- **Waiting Period** ..... 7 days
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $125
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Period **** ..... 52 weeks
- **Maximum Benefit Period** for Hernia……...….10 weeks

Continuous Total Disability Benefit: ***
- **Waiting Period** ..... **Maximum Benefit Period** for **Temporary Total Disability**
- Benefit Percentage 70%
- **Minimum Weekly Benefit Amount** $50
- **Maximum Weekly Benefit Amount** $400
- **Maximum Benefit Amount** $200,000
- **Maximum Benefit Period** ..... to age 70

Accident Medical Expense Benefit:
- **Medical Commencement Period** ..... 90 days
- **Deductible Amount** $0
- **Maximum Benefit Period** ..... 52 weeks
- Dental Maximum ..... $1,000 per **Accident**
- **Maximum Benefit Amount** per **Accident** $300,000
- Lifetime **Maximum Benefit** $300,000

Limits on **Accident Medical Expense** Benefits:
- Physical Therapy, Occupational Therapy, Work Hardening Therapy…… ..... $3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….……...…..$1,000 per **Injury**
- Ambulance …….…..... one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance……..…….…….…..... one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- Hernia Coverage…….....lifetime **Maximum Benefit** of $10,000
- **Mental and Nervous –** Outpatient…….....….. $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient……..…..maximum $1,000 for any one **Accident**

Occupational Accident Limits of Liability

- **Combined Single Limit** $300,000
- **Aggregate Limit of Liability** $600,000
  (Applicable to all **Covered Losses** with respect to any one **Occupational Accident**)

NON-OCCUPATIONAL ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum * .....…$15,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
Principal Sum *.. .....$15,000
Accident Commencement Period……...…...365 days

Accident Medical Expense Benefit:
Medical Commencement Period ..... 90 days
Deductible Amount $0
Maximum Benefit Period.....52 weeks
Dental Maximum ..... $1,000 per **Accident**
Maximum Benefit Amount per **Accident**.....$5,000
Lifetime **Maximum Benefit** $10,000

Limits on **Accident Medical Expense** Benefits:

- Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$3,600 per **Injury**
- Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy…….....$1,000 per **Injury**
- Ambulance……..……one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
- Air Ambulance…….....one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
- **Mental and Nervous –** Outpatient……..……...……..... $25 per visit maximum 20 visits for any one **Accident**
- **Mental and Nervous –** Inpatient…….maximum $1,000 for any one **Accident**

Non-Occupational Accident Limits of Liability

- **Combined Single Limit** $15,000
- **Aggregate Limit of Liability**……...$30,000
  (Applicable to all **Covered Losses** with respect to any one **Non-Occupational Accident)**

*At age 65, **Your Principal Sum** shall be based on the following schedule**:**

Age at Date of Loss	% of **Principal Sum**
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

** If **You** sustain a **Covered Injury** at or after age 70, the **Maximum Benefit Period** shall be one (1) year.

***If **You** sustain a **Covered Injury** after **Your** normal Social Security retirement age, as determined by federal law, **You** cannot qualify for **Continuous Total Disability**.]

SECTION III – PREMIUM

Premium Amount:

PLAN A		**PLAN 1**	
Class I:	$136.00 per **Owner-Operator** per month	Class I:	$146.00 per **Owner-Operator** per month
Class II:	$136.00 per **Contract Driver** per month	Class II:	$146.00 per **Contract Driver** per month
Class III:	$136.00 per **Employee Driver** per month	Class III:	$146.00 per **Employee Driver** per month
PLAN B		**PLAN 2**	
Class I:	$126.00 per **Owner-Operator** per month	Class I:	$136.00 per **Owner-Operator** per month
Class II:	$126.00 per **Contract Driver** per month	Class II:	$136.00 per **Contract Driver** per month
Class III:	$126.00 per **Employee Driver** per month	Class III:	$136.00 per **Employee Driver** per month
[PLAN C		**[PLAN 3**	
Class I:	$118.00 per **Owner-Operator** per month	Class I:	$125.00 per **Owner-Operator** per month
Class II:	$118.00 per **Contract Driver** per month	Class II:	$125.00 per **Contract Driver** per month
Class III:	$118.00 per **Employee Driver** per month]	Class III:	$125.00 per **Employee Driver** per month]

Grace Period: A Grace Period of thirty-one (31) days will be provided for the payment of any premium due after the first premium. **Your** coverage will not be terminated for nonpayment of premium during the Grace Period if **You** pay the premiums due by the last day of the Grace Period. **Your** coverage will terminate if all premiums due are not paid by the last day of the Grace Period.

No Grace Period will be provided if **We** receive notice to terminate **Your** coverage prior to a premium due date.

Waiver of Premium: Subject to the **Policy** remaining in force, all premiums due under the **Policy** with respect to **You** receiving either a **Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit under the **Policy** will be waived. Premiums will be waived from the first premium due date on or after the date the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit begins. Premium payments must be resumed on the premium due date next following the date **Your Temporary Total Disability** Benefit or **Continuous Total Disability** Benefit ceases. If premium payments are not resumed on that date, **Your** coverage under the **Policy** will end on that date. **You** are responsible for reporting Waiver of Premium to the **Program Administrator** or its designated agent.

SECTION IV – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Injury** to **You** results in death within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the **Principal Sum** shown in the **Schedule**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If **You** suffer an **Accidental** Death such that an **Accidental** Death Benefit is payable under the **Policy**, **We** will pay the beneficiary in accordance with the Payment of Claims provision.

Survivor's Benefit

The Monthly Benefit Amount will be as described in the **Schedule**. The Monthly Benefit Amount will be paid to **Your** surviving **Spouse** up to the **Principal Sum** shown in the **Schedule**.

If **You** are not survived by a **Spouse,** or if **Your Spouse** dies or remarries, **We** will pay or continue to pay the Survivor's Benefit to **Your** surviving **Dependent Child(ren)**, if any. If there is more than one surviving **Dependent Child**, the Survivor's Benefit will be distributed equally among the surviving **Dependent Children**. The payment of the monthly Survivor's Benefit will end on the earliest of the following dates:

1. the date **Your Spouse** dies or remarries, if there are no **Dependent Child(ren)**;

2. the date the last **Dependent Child** dies or is no longer eligible as defined in the GENERAL DEFINITIONS Section of the**Policy**; or
3. the date the **Principal Sum** has been paid.

If **You** are not survived by a **Spouse** or any **Dependent Child(ren)**, **We** will pay only the **Accidental** Death Benefit in accordance with the Payment of Claims provision of the **Policy**. **We** will not pay a Survivor's Benefit.

Exposure and Disappearance

If **You** are exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If **Your** body has not been found within 365 days after the disappearance, stranding, sinking or wrecking of a power unit in which **You** were an occupant, then it will be presumed, subject to all other terms and provisions of the **Policy**, that **You** have suffered **Accidental** Death within the meaning of the **Policy**. If **You** are subsequently found alive and identified, **We** have the right to recover any benefits paid.

ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to **You** results in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

For **Covered Loss** of:	Percentage of the **Principal Sum**
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
One Hand or One Foot	50%
Sight of One Eye	50%
Thumb and Index Finger of Same Hand	25%

For purposes of the **Accidental** Dismemberment Benefit, **Loss** will mean:

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. **Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits**.**

If more than one **Loss** is sustained by **You** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

PARALYSIS BENEFIT (does not apply to a **Non-Occupational Accident**)

If a **Covered Injury** to **You** results in any Type of Paralysis specified below, within the **Accident Commencement Period** shown in the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below.

Type of Paralysis:	Percentage of the **Principal Sum**
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%

Quadriplegia means the complete and irreversible paralysis of both upper and both lower **Limbs**. **Paraplegia** means the complete and irreversible paralysis of both lower **Limbs**. **Hemiplegia** means the complete and irreversible paralysis of the upper and lower **Limbs** of the same side of the body. **Uniplegia** means the complete and irreversible paralysis of one **Limb**. For purposes of this benefit **Limb** means entire arm or entire leg.

If **You** sustain more than one Type of Paralysis as a result of the same **Covered Accident**, only the largest single amount will be considered a **Covered Loss**.

TEMPORARY TOTAL DISABILITY (TTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

TTD Benefit Qualifications.

If a **Covered Injury** to **You** results in **Temporary Total Disability** within the **Disability Commencement Period** shown in the **Schedule**, **We** will pay the **Temporary Total Disability** Benefit specified below, subject to satisfaction of any applicable **Waiting Period** shown in the **Schedule**. **The Disability Commencement Period** starts on the date of the **Accident** that caused such **Injury**. After the **Waiting Period** has been satisfied, the **Temporary Total Disability** Benefit will be payable from the day the **Waiting Period** was satisfied.

TTD Benefit Amount.

The **Temporary Total Disability** Benefit with respect to each week of **Your Temporary Total Disability** during a **Single Period of Total Disability** is equal to the lesser of:

1. the Benefit Percentage (as shown in the **Schedule**) of **Your Average Weekly Earnings**; or
2. the **Maximum Weekly Benefit Amount** shown in the **Schedule**.

In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Temporary Total Disability** Benefit with respect to less than a full **Benefit Week** of **Temporary Total Disability** equals 1/7th of the **Weekly Benefit Amount** for each day of **Temporary Total Disability**.

TTD Benefit Calculation.

For the purposes of this **Temporary Total Disability** Benefit, **Average Weekly Earnings** will be calculated as follows**:**

- If **You** are a Class I **Owner-Operator**:

  Thirty-three percent (33%) of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by 52, regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during the prior year, then thirty-three percent (33%) of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than fifty (50) weeks.

- If **You** are a Class II **Contract Driver**:

  Seventy-five percent (75%) of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during the prior year, then seventy-five percent (75%) of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than fifty (50) weeks.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but have worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and have not worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the current year, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

TTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: 1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your** Disability; 2) Social Security Retirement Benefits; 3) Individual or Group Disability Benefits; 4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; 5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and 6) any income from employment or services, or from leasing **Your** power unit. **You** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

TTD Benefit Termination.

The **Temporary Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Temporarily Totally Disabled**;
2. the date the **Maximum Benefit Period** shown in the **Schedule** has been reached;

3. the date on which the **Temporary Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
4. the date **You** die.

TTD Benefit Definitions.

As used in this **Temporary Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the first day of **Temporary Total Disability** after the **Waiting Period** shown in the **Schedule** for **Temporary Total Disability**, and on the same day of each week thereafter.

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Temporary Total Disability** on a monthly basis.

Disability Commencement Period means the time period, shown in the **Schedule**, between the date of the **Accident** that caused the **Injury** and the date that **Temporary Total Disability** must begin for disability benefits to be payable under the **Policy**.

Maximum Benefit Period means, with respect to **Temporary Total Disability**, the maximum period for which benefits will be payable for a **Temporary Total Disability Covered Loss** during a **Single Period of Total Disability**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Temporary Total Disability** is shown in the **Schedule**.

Single Period of Total Disability means all periods of **Temporary Total Disability** due to the same or related causes (whether or not insurance has been interrupted) except any of the following which are considered separate periods of disability: 1) successive periods of **Temporary Total Disability** due to entirely different and unrelated causes, separated by at least one (1) full day during which **You** are not **Temporarily Totally Disabled**; 2) successive periods of **Temporary Total Disability** due to the same or related causes, separated by at least six (6) months during which **You** are not **Temporarily Totally Disabled**.

Temporary Total Disability or **Temporarily Totally Disabled** means disability that: 1) prevents **You** from performing the **Material and Substantial Duties** of **Your** occupation as a commercial truck driver; 2) requires the care and treatment of a **Physician**; and 3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for the **Temporary Total Disability** Benefit.

For purposes of this section "**Material and Substantial Duties**" will mean a duty or duties which **You** are required to perform as an **Owner-Operator**, **Contract Driver** or **Employee Driver**.

CONTINUOUS TOTAL DISABILITY (CTD) BENEFIT (does not apply to a **Non-Occupational Accident**)

CTD Benefit Qualifications.

If a **Covered Injury** to **You** resulting in **Temporary Total Disability**, subsequently results in **Continuous Total Disability**, **We** will pay the **Continuous Total Disability** Benefit specified below, provided:

1. the benefits payable for the **Temporary Total Disability Covered Loss** ceased solely because the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached, but **You** remain disabled;
2. **You** are under the normal Social Security retirement age, as determined by federal law, on the day after the **Maximum Benefit Period** shown in the **Schedule** for **Temporary Total Disability** has been reached;
3. **You** have been granted a Social Security Disability Award for **Your** disability (If **You** cannot meet the credit requirement for a Social Security Award, **You** cannot qualify for the **Continuous Total Disability** Benefit even if **You** would otherwise qualify.);
4. **Your** disability is reasonably expected to continue without interruption until You die, and is substantiated by objective medical evidence satisfactory to **Us**;
5. the **Injury** began within the **Disability Commencement Period** shown in the **Schedule**; and
6. the **Temporary Total Disability** was not principally due to a **Mental and Nervous or Depressive Condition**. (If the **Temporary Total Disability** was principally due to a **Mental and Nervous or Depressive Condition**, **You** do not qualify for a **Continuous Total Disability** Benefit.)

You cannot qualify for a **Continuous Total Disability** Benefit unless **You** qualified for a **Temporary Total Disability** Benefit for the same **Covered Injury**.

Sunset Period: If **You** are not granted a Social Security Award for **Your** disability within two (2) years of the **Injury**, **You** cannot qualify for a **Continuous Total Disability** Benefit even if **You** would otherwise qualify.

CTD Benefit Amount.

The **Weekly Benefit Amount** will be the lesser of the benefit percentage, as shown in the **Schedule**, of the **Average Weekly Earnings**, or the **Maximum Weekly Benefit Amount** as shown in the **Schedule**. In no event will the **Weekly Benefit Amount** be less than the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

The **Continuous Total Disability** Benefit with respect to less than a full **Benefit Week** of **Continuous Total Disability** equals 1/7th of the **Weekly Benefit** for each day of **Continuous Total Disability**.

CTD Benefit Calculation.

For purposes of this **Continuous Total Disability** Benefit**, Average Weekly Earnings** will be calculated as follows:

- If **You** are a Class I **Owner-Operator**:

  Thirty-three percent (33%) of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by 52, regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during the prior year, then thirty-three percent (33%) of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s, divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked if **You** are claiming less than fifty (50) weeks.

- If **You** are a Class II **Contract Driver**:

  Seventy-five percent (75%) of the gross income **You** received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by 52 regardless of **Your** prior occupation. If **You** worked less than fifty (50) weeks during the prior year, then seventy-five percent (75%) of the gross income received in the prior year as shown in **Your** federal income tax return with schedules or 1099s or similar wage reporting documents divided by the number of weeks worked, regardless of **Your** prior occupation. **You** will have to produce proof, which is satisfactory to **Us**, of the number of weeks worked, if **You** are claiming less than fifty (50) weeks.

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year but have worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the current year, **We** will divide the gross income earned in the current year by the number of weeks worked in the current year. **You** will have to produce proof, which is satisfactory to **Us**, of **Your** gross income and the number of weeks worked**.**

If **You** did not file a federal income tax return or receive 1099s or similar wage reporting documents for the prior year and have not worked as an **Owner-Operator** or **Contract Driver** for at least twenty-six (26) weeks in the current year, **We** will award **You** the **Minimum Weekly Benefit Amount** as shown in the **Schedule**.

CTD Benefit Offsets.

Subject to the **Minimum Weekly Benefit Amount**, the **Total Disability Benefit** will be reduced by: 1) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your Disability**; 2) Social Security Retirement Benefits; 3) Individual or Group Disability Benefits; 4) the amount of any disability income benefits from any automobile or no-fault policy or insurance; 5) the amount **You** receive as compensation for lost wages or lost income in a lawsuit or the settlement of a lawsuit; and 6) any income from employment or services, or from leasing **Your** power unit. **You** must provide tax schedules and returns to **Us** for the purpose of calculating this offset.

CTD Benefit Termination.

The **Continuous Total Disability** Benefit will cease on the earliest of the following dates:

1. the date **You** are no longer **Continuously Totally Disabled**;
2. the date **Your** Social Security Disability Award ceases;
3. the date **You** attain age 70;
4. the date the **Maximum Benefit Period** shown in the **Schedule** for **Continuous Total Disability** has been reached;
5. the date the **Maximum Benefit Amount** shown in the **Schedule** for **Continuous Total Disability** has been reached;
6. the date on which **Continuous Total Disability** is not substantiated by objective medical evidence satisfactory to **Us**; or
7. the date **You** die.

CTD Benefit Definitions.

As used in this **Continuous Total Disability** Benefit:

Benefit Week means a 7-day period of time that begins on the day after the **Maximum Benefit Period** for **Temporary Total Disability** has been reached, and on the same day of each week thereafter.

Continuous Care means at least quarterly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Continuous Total Disability** on a quarterly basis. These requirements may be waived by **Us**.

Continuous Total Disability or **Continuously Totally Disabled** means disability that: 1) prevents **You** from performing the duties of any occupation for which **You** are qualified by reason of education, training or experience; 2) requires the care and treatment of a **Physician**; and 3) requires that, and results in, **You** receiving **Continuous Care**. If **You** do not adhere to the treatment plan the **Physician** prescribes relating to **Your** disabling condition, **You** will not qualify for a **Continuous Total Disability** Benefit.

If **You** can perform an occupation which would provide an annual gross income equal to or greater than either the gross income from wages and/or the net income reported on Schedule C which **You** filed on **Your** most recent federal income tax return filed prior to the **Covered Injury**, **You** are not **Continuously Totally Disabled**. **You** must provide **Us** with such federal income tax return in order to qualify for a **Continuous Total Disability** Benefit.

Maximum Benefit Amount means, with respect to **Continuous Total Disability**, the maximum benefits payable for **Continuous Total Disability Covered Losses**.

Maximum Benefit Period means, with respect to **Continuous Total Disability**, the maximum period for which benefits will be payable for a **Continuous Total Disability Covered Loss**. The **Maximum Benefit Period** begins after the **Waiting Period**, as indicated in the **Schedule**, has been satisfied. The length of the **Maximum Benefit Period** for **Continuous Total Disability** is shown in the **Schedule**. Benefits payable under the **Temporary Total Disability** Benefit will not be considered **Continuous Total Disability** Benefits for purposes of applying the **Maximum Benefit Period**.

Terms used in this **Continuous Total Disability** Benefit, but which refer to **Temporary Total Disability** and are defined in the **Temporary Total Disability** Benefit, are to be interpreted as defined in that Benefit.

ACCIDENT MEDICAL EXPENSE (AME) BENEFIT

AME Benefit Qualifications.

If **You** suffer an **Injury** that requires **You** to be treated by a **Physician**, within the **Medical Commencement Period** shown in the **Schedule**, **We** will pay the **Usual and Customary Charges** incurred for **Medically Necessary Covered Accident Medical Services** received due to that **Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown in the **Schedule**, per **Insured Person**, for all **Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Injury**. The **Deductible Amount** for the **Accident Medical Expense** Benefit is the **Deductible Amount** shown in the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Injuries** sustained by **You** in that **Covered Accident**.

AME Benefit Covered Accident Medical Services.

1. **Hospital** semi-private room and board (or room and board in an intensive care unit), **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;
2. Services of a **Physician** or a qualified nurse, if under the supervision of a Graduate Registered Nurse (RN), for **Home Health Care** which follows a five (5) day period of **Hospital** confinement and which is prescribed by a **Physician**;
3. Services by a qualified **Physician** for the treatment of a covered **Mental and Nervous Condition** due to a **Covered Injury**. However, such charges will be considered a **Covered Accident Medical Expense** only to the extent that the charges do not exceed $25.00 per visit and are further limited to one (1) visit per day with a maximum of twenty (20) visits. **Hospital** charges for in-patient treatment of a **Mental and Nervous Condition**, whether in a psychiatric **Hospital** or a general **Hospital**, will be considered a **Covered Accident Medical Expense** and will be limited to a maximum benefit of $1,000.
4. Ambulance, including air ambulance, service to or from a **Hospital** for one round trip;
5. Laboratory tests;
6. Radiological procedures;
7. Anesthetics and the administration of anesthetics;
8. Blood, blood products and artificial blood products, and the transfusion thereof;
9. Physical Therapy, Occupational Therapy, Work Hardening Therapy and Chiropractic or Acupuncturist Care as

shown in the **Schedule**;

10. Rental of **Durable Medical Equipment**, up to the actual purchase price of such equipment;
11. The initial supply, but not replacement of: casts, splints, trusses, braces, artificial limbs and artificial eyes subject to the **Accident Medical Expense** Benefit Exclusions section;
12. Medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
13. Repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the Dental Maximum, if any, shown in the **Schedule**;
14. **Extended Care Facilities**; or
15. **Home Health Care**.

The foregoing **Covered Accident Medical Services** are subject to all of the limits as shown in the **Schedule**.

AME Benefit Exclusions.

In addition to the GENERAL EXCLUSIONS in SECTION VI of the **Policy,** charges for **Covered Accident Medical Services** do not include, and benefits are not payable with respect to, any expense for or resulting from:

- repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or repair of existing **Durable Medical Equipment** unless for the purpose of modifying the item because **Injury** has caused further impairment in the underlying bodily condition;
- dentures, bridges, dental implants, or treatment not related to the **Injury**;
- eye glasses or contact lenses;
- hearing aids or hearing examinations;
- that portion of rental expense for **Durable Medical Equipment** that exceeds the usual purchase cost for similar equipment in the locality where the expense is incurred;
- **Custodial Services**;
- **Personal Comfort** or **Convenience Items**;
- services of a Federal, Veteran's, State or Municipal **Hospital** for which **You** are not liable for payment;
- services or treatment which is covered by Medicare;
- that portion of the fee for services or treatment which is more than the **Usual and Customary Charge**;
- cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of an **Injury**;
- services or treatment which are provided for in a settlement or court judgment;
- services or treatment which are covered under any other insurance of any kind;
- services or treatment for which **You** are not legally obligated to pay;
- an **Extended Care Facility** stay that does not follow a **Hospital** confinement of five (5) days or more;
- any mileage charges related to the **Covered Injury** unless authorized by **Us**;
- any translation charges related to the **Covered Injury** unless authorized by **Us**; or
- any lodging charges related to the **Covered Injury** unless authorized by **Us**.

AME Benefit Definitions.

As used in this **Accident Medical Expense** Benefit:

Ambulatory Medical Center means a facility that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An **Ambulatory Medical Center** does not include a **Hospital** or a **Physician's** office or a clinic.

Custodial Services means any services which are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services: 1) related to watching or protecting **You**; 2) related to performing or assisting **You** in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and 3) that are not required to be performed by trained or skilled

medical or paramedical personnel.

Durable Medical Equipment refers to equipment of a type that is designed primarily for use, and used primarily by people who are injured (for example, a wheelchair or a **Hospital** bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of **Injury** or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Extended Care Facility means an institution that meets all of the following requirements:

1. operates under the laws of the state that it is situated in;
2. is approved by the Department of Health and Human Services or its successor;
3. is regularly engaged in providing skilled nursing care of sick or injured persons as inpatients at the patient's expense;
4. provides 24 hour a day nursing service by or under the supervision of a Graduate Registered Nurse (RN);
5. provides skilled nursing care under the supervision of a **Physician**; and
6. maintains a daily medical record of each patient.

Home Health Care means nursing care and treatment of **You** in **Your** home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:

1. be approved in writing by the attending **Physician**;
2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
3. begin within seven (7) days after discharge from a **Hospital**; and
4. follow a **Hospital** confinement of five (5) days or more.

No benefits are payable for **Home Health Care** services provided by:

1. a member of **Your** immediate family; or
2. a person residing in **Your** home.

Hospital means a facility that: 1) operates under the law of the state that it is situated in; 2) is approved by the Department of Health and Human Services or its successor; 3) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; 4) has 24-hour nursing service by graduate registered nurses (RN), on duty or on call; and 5) is supervised by one or more **Physicians**. A **Hospital** does not include: 1) a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care; 2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the **Hospital** that is used for such purposes; or 3) any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Maximum Benefit Period means, with respect to the **Accident Medical Expense** Benefit, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The length of the **Maximum Benefit Period** for **Accident Medical Expense** is shown in the **Schedule**.

Medical Commencement Period means the time period shown in the **Schedule** between the date of the **Accident** that caused the **Injury** and the date that the first medical service or treatment must be incurred for **Accident Medical Expense** Benefits to be payable under the **Policy**.

Medically Necessary means that a **Covered Accident Medical Service**: 1) is essential for diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; 2) meets generally accepted standards of medical practice; and 3) is ordered by a **Physician** and performed under his or her care supervision or order.

Personal Comfort or Convenience Item(s) means those items that are not **Medically Necessary** for the care and treatment of **Your Injury**. The term **Personal Comfort or Convenience Item(s)** includes, but is not limited to: 1) a private **Hospital** room, unless **Medically Necessary**; 2) television rental; and 3) **Hospital** telephone charges.

Sound Natural Teeth means natural teeth that are either unaltered or fully restored to their normal function and are disease free, have no decay, and are not more susceptible to **Injury** than unaltered natural teeth.

Usual and Customary Charge(s) means a charge that is made for a **Covered Accident Medical Expense** Benefit that: 1) does not include charges that would not have been made if no insurance existed; 2) is the lesser of the usual

charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred, or the negotiated rate of the **Preferred Provider** designated by **Us**. For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit; and 3) with respect to drugs, is the negotiated rate of the **Preferred Provider** designated by **Us**, if applicable, or 125% of the Average Wholesale Price (AWP), if applicable.

SECTION V – LIMITATIONS

Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated in the **Schedule**.

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated in the **Schedule**.

Incarceration Limitation.

Benefits being made to **You** will cease while **You** are incarcerated in a penal facility. The benefit will resume, as if the benefits had been paid, subject to all **Policy** conditions, when **You** are released from such facility.

SECTION VI – GENERAL EXCLUSIONS

The **Policy** does not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**, including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation; or any **Injury** resulting from a provoked attack;
- illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
- any **Pre-Existing Condition** until **You** have has been continuously covered under the **Policy** for twelve (12) consecutive months;
- **Cumulative Trauma** and/or **Repetitive Conditions**, unless as shown in the **Schedule**;
- **Occupational Disease**;
- Hernia of any kind, unless as shown in the **Schedule**;
- Hemorrhoids of any kind;
- performing, learning to perform or instructing others to perform as a crew member of any vessel while covered under the Jones Act or the United States Longshoremen and Harbor Workers' Act, or similar coverage;
- war, or any act of war, whether declared or undeclared;
- involvement in any type of active military service;
- any **Injury** for which **You** are entitled to benefits pursuant to any Workers' Compensation Law or other similar legislation;
- any loss insured by employers' liability insurance;
- **You** being intoxicated. **You** are conclusively deemed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether **You** are in fact operating a motor vehicle, when the **Injury** occurs. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication;

- the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions;
- participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot;
- travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if **You** are:
  - **a.** riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - **b.** performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft;
  - **c.** riding as a passenger in an aircraft owned, leased or operated by the **Policyholder** or an **Insured Person**;
- participation in any of the following activities:

skydiving	hang gliding	parachuting	parasailing
automobile racing or stunts	bungee-jumping	scuba diving	heli-skiing
motorcycle racing or stunts	endurance tests	fire fighting	racing
acrobatic or stunt flying	extreme sport stunts	hunting	

  flight on a rocket-propelled or rocket launched aircraft

  or any other extra-hazardous activity;
- a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**; or
- alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority.

SECTION VII – CLAIMS PROVISIONS

Notice. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the loss within twenty (20) days of such loss. The notice must include **Your** name and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-568-2233. The notice must be sent to the Claims Department at Atlantic Specialty Insurance Company, PO Box 1009, Morristown, NJ 07962-1009, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. **We** will send the claimant Proof of Loss (claim) forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the forms in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss**.** The notice should include **Your** name, the **Policyholder's** name and the **Policy** number.

Proof of Loss. Written Proof of Loss, acceptable to **Us**, must be sent within ninety (90) days of the date of the loss. If the loss is one for which the **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as **We** may reasonably require. Failure to furnish Proof of Loss, acceptable to **Us**, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. **We** have a right to investigate the Proof of Loss and any relevant documents which **You** or **Your** beneficiary will make available to **Us** upon request.

Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written Proof of Loss that is acceptable to **Us**.

Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each one (1) week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. Loss of Life. **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
   - **a.** **Your** legally married spouse;
   - **b.** **Your** child(ren);

c. **Your** parents;

d. **Your** brothers and sisters;

e. **Your** estate.

2. All Other Claims. Benefits are paid to **You**. **You** may direct in writing that all or part of an **Accident Medical Expense** Benefit be paid directly to the party who furnished the service. The direction may be changed by **You** at any time up to the filing of the Proof of Loss. If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary, or if there is no beneficiary designated, as set forth above.

Physical Examination and Autopsy. We have the right to examine **You** if **Your Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If **You** suffer a **Covered Loss(es)** as the result of **Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You** receive payment from the third party, **You** agree to refund to **Us** the lesser of: 1) the amount actually paid by **Us** for such **Covered Loss(es)**; or 2) an amount equal to the sum actually received from the third party for such **Covered Loss(es)**. If **You** do not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, or otherwise. This provision will not apply where prohibited by law.

Rehabilitation. We will consider a rehabilitation program for **You** if **You** are receiving benefits under either the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit. The program must be mutually agreed upon by **You** and **Us**. The extent of **Our** participation will be determined by mutual agreement and benefits payable will continue during **Your** rehabilitation.

Sunset. In no event will a claim made for losses sustained by **You** be considered valid and collectible in accordance with the **Policy** unless full details of such claim are presented to **Us** within three (3) years from the date of the **Accident** which is the basis of such claim.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Loss was required to be submitted. If the law of the state where **You** live makes such limit void, then the action must begin within the shortest time period permitted by law.

Recovery. In the event **You** make a recovery from a third party for a loss paid under the **Policy**, You will reimburse **Us** up to the amount of the benefits made by **Us**.

Subrogation. We have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to **You** from anyone liable for the **Covered Injury**. If **You** recover from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**. **You** agree to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.

Claims for Workers' Compensation and Other Insurance. No benefits will be payable under the **Policy** for any loss which **You** claim or file under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance until such claim or filing is approved or denied. Upon approval or denial, **We** will determine **Our** liability under the terms and conditions of the **Policy**. If such a claim is denied, and **You** appeal the denial, no benefits will be paid under the **Policy** until a final disposition of the appeal is issued, at which time **We** will determine **Our** liability. **We** reserve the right to recover, from **You**, any benefits paid under the **Policy** which are subsequently paid for under any Workers' Compensation, employers' liability, occupational disease or similar law or any other insurance.

SECTION VIII – GENERAL PROVISIONS

Beneficiaries. You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue **Your** coverage, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity With Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Assignment of Interest. The **Policy** is non-assignable.

Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.

Noncompliance With Policy Requirements. Any express waiver by **Us** of any requirements of the **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

Offset Debt. We will have, and may exercise at any time, the right to offset any balance or balances, whether on account of premiums or otherwise, due from **You** to **Us** against any balance or balances, whether on account of losses or otherwise, due from **Us** to **You**.

SECTION IX – GENERAL DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Accident Commencement Period** means the time period, shown in the **Schedule**, between the date of the **Accident** which caused the **Injury** and the date the **Loss** must occur for death or dismemberment benefits to be payable under the **Policy**.
- **Actively At Work** means that the person is under **Dispatch** an average of thirty (30) hours each week.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- **Combined Single Limit** means, with respect to any one **Insured Person**, the total amount of benefits that are

payable under the **Policy** for or in connection with a **Covered Injury** sustained as the result of any one **Covered Accident**. When the **Combined Single Limit** has been reached, no further benefits will be payable under the **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident**.

- **Contract Driver** is as described in SECTION I.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while **You** are insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Cumulative Trauma** and/or **Repetitive Conditions** means conditions which impair the normal physiological function of the body over an extended period of time, and which do not arise as the result of a single **Accident**.
- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services,** incurred due to **Injuries** sustained by **You** in a **Covered Accident**, which must be met before the **Accident Medical Expense** Benefit will be paid. The **Deductible Amount** is shown in the **Schedule**.
- **Dependent Child(ren)** means **Your** unmarried children, including natural children from the moment of birth, step or foster children, or adopted children, from the date of the final decree of adoption, who rely on **You** for more than 50% of their support and are taken as dependents on **Your** Federal Income Tax Return, and who are either: 1) less than nineteen (19) years of age; or 2) less than twenty-three (23) years of age and enrolled on a full-time basis in a college, university or trade school, or who satisfy neither 1) nor 2), but who prior to age twenty-three (23), became incapable of self-sustaining employment by reason of mental retardation or physical handicap. **We** may require proof of such **Dependent Child(ren)'s** incapacity and dependency.
- **Dispatch** means when **You** are:
  1. in route to pick up a load;
  2. picking up a load;
  3. in route to deliver a load;
  4. unloading a load;
  5. in route after dropping off a load;
  6. waiting for a load if **You** are not at home;
  7. required to perform services by or for a motor carrier; or
  8. performing activities to comply with federal or state laws to satisfy motor carrier or commercial driving requirements.

  Dispatch must be authorized by the person or company which has engaged **You** to transport goods or freight for compensation. **Dispatch** does not include an **Injury** during usual travel between, to, and from work or a bona fide leave of absence or vacation.

  For purposes of the **Policy**, if **You** are performing maintenance and/or repairs on a power unit which **You** own or lease, **You** will be deemed to be under **Dispatch**. **You** must provide proof which is satisfactory to **Us** that the **Injury** was sustained while performing such maintenance or repairs in order to receive **Occupational Accident Benefits** for the **Injury**.

- **Eligible Person** means a person who is described in the ELIGIBILITY portion of SECTION I.
- **Employee Driver** is as described in SECTION I.
- **Immediate Family Member** means a person who is related to **You** in any of the following ways: **Spouse**, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or placed for adoption, or stepchild) or any person residing in **Your** home.
- **Injury** or **Injuries** means bodily harm or bodily damage.

- **Insured Person** means a person who: 1) is an **Eligible Person** as described in the ELIGIBILITY portion of SECTION I; 2) has enrolled for coverage; and 3) has coverage in effect according to the terms of the **Policy**.

- **Mental and Nervous** or **Depressive Condition** means mental, nervous or emotional diseases or disorders of any type including schizophrenia, dementia, organic brain syndrome, delirium, amnesia syndromes, and organic delusional or hallucinogenic syndromes.

- **Non-Occupational** means an activity involving **You**, which occurs while **You** are not under **Dispatch**.

- **Occupational** means an activity involving **You**, which occurs or arises out of or in the course of **You** performing services while under **Dispatch**. **Occupational** does not encompass any period of time during the course of everyday travel to and from work or while on vacation.

- **Occupational Assessment** means a test of vocational capabilities. The process includes a review of medical records, **Injury** and treatment, history and background (education, military, previous occupation(s)), evaluation of basic skills such as reading, understanding, spelling and/or math capabilities, and vocational alternatives.

- **Occupational Cumulative Trauma** and/or **Repetitive Conditions** means bodily **Injury** to **You** caused by the combined effect of repetitive physical **Occupational** activities extending over a period of time, where: 1) such condition is diagnosed by a **Physician**; 2) **Your** performance of the activities causing the **Injury** occurred during the **Policy** period, and the onset of the **Injury** occurred and was reported during the **Policy** period; and 3) such activities resulted directly and independently of all other causes in a **Covered Loss**.

- **Occupational Disease** means a sickness which results in disability or death, and is caused by exposure to environmental or physical hazards during the course of **Your Occupational** activities, where: 1) such condition is diagnosed by a **Physician**, and is generally accepted by the National Centers for Disease Control to be a disease caused by such hazards; 2) exposure to such hazards is not an **Accident** but is caused or aggravated by the conditions under which **You** perform **Occupational** services; 3) **Your** last day of last exposure to the environmental or physical hazards causing such condition occurs during the **Policy** Period; and 4) such exposure results directly and independently of all other causes in a **Covered Loss**.

- **Owner-Operator** is as described in SECTION I.

- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: 1) **You**; or 2) an **Immediate Family Member**.

- **Policy** means the **Occupational Accident** Insurance **Policy**.

- **Policyholder** means the group named on the front page of the **Policy**.

- **Pre-Existing Condition** means a condition for which **You** have sought or received medical advice or treatment during the twelve (12) months immediately preceding **Your** effective date of coverage under the **Policy**.

- **Preferred Provider** means a **Physician** or **Hospital** with which **We** have an agreement or contract to perform a covered service or treatment at an agreed upon rate or a company which provides prescription drugs at an agreed upon rate to **You**.

- **Principal Sum**, as applicable to **You**, means the amount of insurance in force under the **Policy** as described in the **Schedule**.

- **Program Administrator** means the Producer designated by **Us** or the person designated by the **Trust** to review and approve or decline the enrollment form submitted by an **Owner-Operator**, **Contract Driver** or **Employee Driver**; issue certificates of insurance; collect and remit premium; and perform other services on behalf of **Us** or the **Policyholder**.

- **Schedule** is SECTION II of the **Policy**.

- **Spouse** means **Your** legally married spouse.

- **Trust** is the Independent Contractor Trust, established by Atlantic Specialty Insurance Company, and The Employers' Fire Insurance Company on February 1, 2008 with the Christiana Bank & Trust Company.

- **Waiting Period** means the consecutive number of days **You** must be **Temporarily Totally Disabled** or

Continuously Totally Disabled before benefits become payable under the **Temporary Total Disability** Benefit or the **Continuous Total Disability** Benefit provisions of the **Policy**. **Benefits are not retroactive to the first day of disability.** The **Waiting Period** is shown in the **Schedule**.

- **We**, **Us**, and **Our** refers to Atlantic Specialty Insurance Company.
- **You** and **Your** refers to the **Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

ENDORSEMENT #1

TRAVEL ASSISTANCE ENDORSEMENT

Travel Assistance will be available to the following **Covered Persons** when they are traveling 100 miles or more from the **Insured Person's Principal Residence**: the **Insured Person** and his or her **Spouse** and/or **Dependent Child(ren)**, if the **Spouse** and/or **Dependent Child(ren)** are with the **Insured Person** while he or she is covered under the **Policy**. The **Spouse** and/or **Dependent Child(ren)** will not be covered while making a trip without the **Insured Person**. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under the **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

  Medical Evacuation
  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

  For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

  Assisted Repatriation
  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the **Insured Person's Principal Residence,** or to the **Insured Person's** residence in the country where the **Insured Person** is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

  Post-Recovery Repatriation
  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to the **Insured Person's Principal Residence** or to the country where the **Insured Person** is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion.

  Return of Remains
  If a **Covered Person** dies while on a **Covered Trip, We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

  Visit to Hospital
  If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

Return of Child
If an **Insured Person** is **Injured** or **Ill** while traveling with his or her **Dependent Child(ren)** on a **Covered Trip**, causing such **Dependent Child(ren)** to be left unattended, **We** will arrange and pay for the transport of the **Dependent Child(ren)** and for an attendant, if applicable. They will be transported by a regularly scheduled economy class air flight to the location chosen by the **Insured Person**. **We** must pre-authorize the transportation of the **Dependent Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion
If a **Covered Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable.

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VI General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions. This exclusion shall not apply to the ingestion of alcohol;
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services.

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of **Travel Assistance** only, the following definitions apply:

Covered Trip means when a **Covered Person** is traveling more than 100 miles from the **Insured Person's Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

Principal Residence means the legal domicile of the **Insured Person.**

Western Medical Standards means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy,** the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Reservation of Rights
We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.

Scope
Illness, as covered under **Travel Assistance,** is solely covered under **Travel Assistance,** and in no way supercedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call:

Toll free:**1-800-586-0740**
Collect: **1-410-308-7960**

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

ENDORSEMENT #2

AUTHORIZED PASSENGER ACCIDENT COVERAGE ENDORSEMENT

Authorized Passengers who are traveling with **You** will be covered under the **Policy**, provided such **Authorized Passengers** are traveling with **You** while **You** are under **Dispatch**. **Your Authorized Passengers** will be covered for the following benefits:

AUTHORIZED PASSENGER ACCIDENT BENEFITS

Accidental Death Benefit:
Principal Sum *.....$100,000
Accident Commencement Period..... 365 days

Accidental Dismemberment Benefit:
Principal Sum *.....$100,000
Accident Commencement Period..... 365 days

Paralysis Benefit:
Principal Sum *.....$100,000
Accident Commencement Period..... 365 days

Accident Medical Expense Benefit:
Medical Commencement Period ..... 90 days
Deductible Amount $50
Maximum Benefit Period.....52 weeks
Dental Maximum.....$1,000 per **Accident**
Maximum Benefit Amount per **Accident** $100,000
Lifetime **Maximum Benefit** $100,000

Limits on **Accident Medical Expense** Benefits:
Physical Therapy, Occupational Therapy, Work Hardening Therapy……...$3,600 per **Injury**
Services provided by a Chiropractor or Acupuncturist, not including Physical Therapy, Occupational Therapy, Work Hardening Therapy……...….$1,000 per **Injury**
Ambulance…….…….one round trip to and from a Hospital but not more than $1,000 for any one **Accident**
Air Ambulance……..…….…...one round trip to and from a Hospital but not more than $7,000 for any one **Accident**
Mental and Nervous – Outpatient…….…….……..…$25.00 per visit maximum 20 visits for any one **Accident**
Mental and Nervous – Inpatient…….....maximum $1,000 for any one **Accident**

Authorized Passenger Accident Benefits Limits of Liability

- **Combined Single Limit**.....$100,000
- **Aggregate Limit of Liability**.....$200,000
  (applicable to all **Covered Losses** with respect to any one **Authorized Passenger Accident)**

* The **Authorized Passenger's Principal Sum** will be based on the following schedule:

Age at Date of Loss	% of **Principal Sum**
18 and younger	10%
19-64	100%
65	80%
66	60%
67	40%
68	20%
69	15%
70 and over	10%

COVERAGE EFFECTIVE DATE

Coverage for **Your Authorized Passenger** will begin on the date he or she becomes an **Authorized Passenger** as indicated below, provided **Your Passenger Accident** coverage is in effect at that time and the required premium has been paid when due.

COVERAGE TERMINATION DATE

Your Authorized Passenger's coverage under the **Policy** ends on the earliest of:

1. the date the **Policy** is terminated;

2. the date **Your Authorized Passenger** is no longer traveling with **You** while **You** are under **Dispatch**;

3. the date **Your** coverage ceases.

Termination of coverage will not affect a claim for a **Covered Loss** that occurs either before or after such termination, if that **Covered Loss** results from an **Accident** that occurred while **Your Authorized Passenger's** coverage was in force under the **Policy**.

PREMIUM

$ 15.00 per month

DEFINITIONS

- **Authorized Passenger** means a person who is traveling with **You**, while **You** are under **Dispatch**, provided **You** have selected and paid the required premium for **Passenger Accident** coverage. **Your Authorized Passenger** can not operate **Your** vehicle, load or unload cargo, secure or unsecure cargo, fuel, or participate in any other activity of **Your** vehicle. In no event will the term "**Passenger**" include a hitchhiker.

- **Authorized Passenger Accident Benefits** means the benefits **We** will pay for **Covered Losses** due to an **Accident** sustained by **Your Authorized Passenger** who is traveling with **You** while **You** are under **Dispatch**. Under no circumstances, will **We** pay for losses to a passenger while he or she is traveling with an **Owner-Operator**, **Contract Driver** or **Employee Driver** who is not covered under the **Occupational Accident Policy**.

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Endorsement #2

OneBeacon INSURANCE

Independent Contractor Trust

OCCUPATIONAL ACCIDENT
ENROLLMENT AND BENEFICIARY DESIGNATION FORM

This form must be complete, signed and dated before it can be processed and coverage can be put into effect.

Please indicate which Plan you are enrolling in: **Plan A** ☐ **Plan B** ☐ **Plan C** ☐

Do you wish to purchase coverage for your Authorized Passengers? **Yes** ☐ **No** ☐

Individual Driver Information: (please print)

Name[/Member #]: _____

Address: _____

City: _____

State: _____ Zip: _____

Social Security Number: _____

Date of Birth: _____

Home Telephone Number: _____

Cell Phone Number: _____

E-mail Address: _____

Beneficiary: _____

Relationship to Beneficiary: _____

Address of Beneficiary: _____

_____

ICC Number: _____

CDL Number: _____

Number of Years Experience: _____

Contracted By (Name of Company): _____

_____

Address: _____

City: _____

State: _____ Zip: _____

Effective Date of Contract: _____

Motor Carrier Phone Number: _____

Motor Carrier Fax Number: _____

Motor Carrier E-mail Address: _____

_____

General Information:

Are you an Owner/Operator: a) with your own authority? Yes ☐ No ☐ b) leased to a Motor Carrier? Yes ☐ No ☐

If no to both of the above, are you a: Co-Driver ☐ Contract Driver ☐ (and you receive a Form 1099) Employee Driver ☐ (and you receive a Form W-2)

Are you a team driver? Yes ☐ No ☐

Trailer type used? Dry Van ☐ Refer ☐ Box ☐ Flat Bed ☐ Dump ☐ Other_____

Years of experience hauling the above type trailer? _____

Do you haul any Oversize or Overweight loads, or pull any double trailers? Yes ☐ No ☐ If so, which?_____

Type of Carriage? Truck Load ☐ LTL ☐

Do you load/unload? Yes ☐ No ☐

If yes, what is the average weight you lift? _____

Do you attach and detach the trailer? Yes ☐ No ☐

Do you tarp? Yes ☐ No ☐ Do you strap? Yes ☐ No ☐

What do you haul? _____

What other duties do you perform? _____

Are you covered under any medical plan? Yes ☐ No ☐

If yes, please provide name of carrier: _____

I hereby authorize the Program Administrator to bill the following selected party for my Occupational Accident coverage:

☐ Self ☐ Motor Carrier, as listed on the front of this Form

☐ Other: _____

Name

_____

Street/PO Box

_____

City State Zip

I understand that the cost of the insurance is my sole obligation and responsibility. I agree that I will forward any amount due to the Program Administrator upon demand, for any insurance at any time my account remains unpaid.

I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier above nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to Atlantic Specialty Insurance Company, or the Program Administrator or its designated representative. A photographic copy of this authorization shall be as valid as the original.
4. I am 18 years of age or older and I am under dispatch an average of 30 hours each week.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee. Or I am an employee, and I receive a W-2 form, but I am exempt from Workers' Compensation insurance; I understand that my employer and I must sign a certificate of exemption form to substantiate this.

PARTICIPATION IN TRUST

I understand and acknowledge that by enrolling for insurance coverage I will become a Participant in the Independent Contractor Trust and that I must abide by the terms and conditions of the Trust. A copy of the Trust Agreement will be provided at the Enrollee's request. Please write to: Atlantic Specialty Insurance Company at 1000 Woodbury Road, Woodbury, NY 11797, Attn: John Ruvolo.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

IF THE INFORMATION YOU HAVE PROVIDED IS FRAUDULENT,
WE MAY HAVE THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information you have provided, you are giving us authority to examine the records that are maintained by the motor carrier and the Program Administrator.

Enrollee's Signature: _____ **Date:** _____

Agent/Producer Signature: _____ **Date:** _____

Agent/Producer Code (if known): _____

Note: The information below is only a brief description of the coverage provided under this group program. Refer to the Policy which provides the contract of insurance for a description of benefits, limitations and exclusions.

OCCUPATIONAL ACCIDENT BENEFITS	A	B	C
ACCIDENTAL DEATH			
Principal Sum	$ 50,000	$ 25,000	$ 25,000
Survivor's Benefit	200,000	125,000	125,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$250,000	$150,000	$150,000
Monthly Benefit	2,000	1,250	1,250
Paralysis Benefit	250,000	150,000	150,000
Accident Commencement Period	365 days	365 days	365 days
TEMPORARY TOTAL DISABILITY			
Disability Commencement Period	90 days	90 days	90 days
Waiting Period	7 days	7 days	7 days
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Period	104 wks	52 wks	52 wks
CONTINUOUS TOTAL DISABILITY			
Waiting Period	104 wks	52 wks	52 wks
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Amount	400,000	300,000	200,000
Maximum Benefit Period	to age 70	to age 70	to age 70
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	104 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	1,000,000	500,000	300,000
Lifetime Maximum Benefit	1,000,000	500,000	300,000

NON-OCCUPATIONAL ACCIDENT BENEFITS	A	B	C
ACCIDENTAL DEATH			
Principal Sum	$ 10,000	$ 10,000	$ 10,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$ 10,000	$ 10,000	$ 10,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	52 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	5,000	5,000	5,000
Lifetime Maximum Benefit	10,000	10,000	10,000

LIMITS OF LIABILITY

OCCUPATIONAL COVERAGE:			
Combined Single Limit	$1,000,000	$500,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	2,000,000	1,000,000	600,000
NON-OCCUPATIONAL COVERAGE:			
Combined Single Limit	$ 10,000	$ 10,000	$ 10,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	20,000	20,000	20,000

MONTHLY RATE PER DRIVER**:** **PLAN A**: $136.00 **PLAN B**: $126.00 **PLAN C**: $118.00

PASSENGER ACCIDENT BENEFITS

ACCIDENTAL DEATH	
Principal Sum	$ 100,000
Accident Commencement Period	365 days
ACCIDENTAL DISMEMBERMENT	
% of Principal Sum of	$ 100,000
Paralysis Benefit	$ 100,000
Accident Commencement Period	365 days
ACCIDENT MEDICAL EXPENSE	
Medical Commencement Period	90 days
Deductible Amount	$ 50
Maximum Benefit Period	52 weeks
Dental Maximum per Accident	$ 1,000
Maximum Benefit Amt per Accident	$ 100,000
Lifetime Maximum Benefit	$ 100,000

LIMITS OF LIABILITY

PASSENGER ACCIDENT COVERAGE	
Combined Single Limit	$ 100,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$ 200,000

MONTHLY RATE PER DRIVER FOR **PASSENGER ACCIDENT COVERAGE**: $10.00

OneBeacon INSURANCE

Independent Contractor Trust

OCCUPATIONAL ACCIDENT
ENROLLMENT AND BENEFICIARY DESIGNATION FORM

This form must be complete, signed and dated before it can be processed and coverage can be put into effect.

Please indicate which Plan you are enrolling in: **Plan 1** ☐ **Plan 2** ☐ **Plan 3** ☐
Do you wish to purchase coverage for your Authorized Passengers? **Yes** ☐ **No** ☐

Individual Driver Information: (please print)

Name[/Member #]: _____
Address: _____
City: _____
State: _____ Zip: _____
Social Security Number: _____
Date of Birth: _____
Home Telephone Number: _____
Cell Phone Number: _____
E-mail Address: _____
Beneficiary: _____
Relationship to Beneficiary: _____
Address of Beneficiary: _____
_____

ICC Number: _____
CDL Number: _____
Number of Years Experience: _____
Contracted By (Name of Company): _____
_____
Address: _____
City: _____
State: _____ Zip: _____
Effective Date of Contract: _____
Motor Carrier Phone Number: _____
Motor Carrier Fax Number: _____
Motor Carrier E-mail Address: _____
_____

General Information:

Are you an Owner/Operator: a) with your own authority? Yes ☐ No ☐ b) leased to a Motor Carrier? Yes ☐ No ☐
If no to both of the above, are you a: Co-Driver ☐ Contract Driver ☐ (and you receive a Form 1099) Employee Driver ☐ (and you receive a Form W-2)

Are you a team driver? Yes ☐ No ☐

Trailer type used? Dry Van ☐ Refer ☐ Box ☐ Flat Bed ☐ Dump ☐ Other_____

Years of experience hauling the above type trailer? _____

Do you haul any Oversize or Overweight loads, or pull any double trailers? Yes ☐ No ☐ If so, which?_____

Type of Carriage? Truck Load ☐ LTL ☐

Do you load/unload? Yes ☐ No ☐
If yes, what is the average weight you lift? _____

Do you attach and detach the trailer? Yes ☐ No ☐

Do you tarp? Yes ☐ No ☐ Do you strap? Yes ☐ No ☐

What do you haul? _____

What other duties do you perform? _____

Are you covered under any medical plan? Yes ☐ No ☐

If yes, please provide name of carrier: _____

I hereby authorize the Program Administrator to bill the following selected party for my Occupational Accident coverage:

☐ Self ☐ Motor Carrier, as listed on the front of this Form

☐ Other: _____
Name

_____
Street/PO Box

_____
City State Zip

I understand that the cost of the insurance is my sole obligation and responsibility. I agree that I will forward any amount due to the Program Administrator upon demand, for any insurance at any time my account remains unpaid.

I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier above nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to Atlantic Specialty Insurance Company, or the Program Administrator or its designated representative. A photographic copy of this authorization shall be as valid as the original.
4. I am 18 years of age or older and I am under dispatch an average of 30 hours each week.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee. Or I am an employee, and I receive a W-2 form, but I am exempt from Workers' Compensation insurance; I understand that my employer and I must sign a certificate of exemption form to substantiate this.

PARTICIPATION IN TRUST

I understand and acknowledge that by enrolling for insurance coverage I will become a Participant in the Independent Contractor Trust and that I must abide by the terms and conditions of the Trust. A copy of the Trust Agreement will be provided at the Enrollee's request. Please write to: Atlantic Specialty Insurance Company at 1000 Woodbury Road, Woodbury, NY 11797, Attn: John Ruvolo.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

IF THE INFORMATION YOU HAVE PROVIDED IS FRAUDULENT,
WE MAY HAVE THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information you have provided, you are giving us authority to examine the records that are maintained by the motor carrier and the Program Administrator.

Enrollee's Signature: _____ **Date:** _____

Agent/Producer Signature: _____ **Date:** _____

Agent/Producer Code (if known): _____

Note: The information below is only a brief description of the coverage provided under this group program. Refer to the Policy which provides the contract of insurance for a description of benefits, limitations and exclusions.

OCCUPATIONAL ACCIDENT BENEFITS	**1**	**2**	**3**
ACCIDENTAL DEATH			
Principal Sum	$ 50,000	$ 25,000	$ 25,000
Survivor's Benefit	200,000	125,000	125,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$250,000	$150,000	$150,000
Monthly Benefit	2,000	1,250	1,250
Paralysis Benefit	250,000	150,000	150,000
Accident Commencement Period	365 days	365 days	365 days
TEMPORARY TOTAL DISABILITY			
Disability Commencement Period	90 days	90 days	90 days
Waiting Period	7 days	7 days	7 days
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Period	104 wks	52 wks	52 wks
CONTINUOUS TOTAL DISABILITY			
Waiting Period	104 wks	52 wks	52 wks
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Amount	400,000	300,000	200,000
Maximum Benefit Period	to age 70	to age 70	to age 70
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	104 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	1,000,000	500,000	300,000
Lifetime Maximum Benefit	1,000,000	500,000	300,000

NON-OCCUPATIONAL ACCIDENT BENEFITS	**1**	**2**	**3**
ACCIDENTAL DEATH			
Principal Sum	$ 15,000	$ 15,000	$ 15,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$ 15,000	$ 15,000	$ 15,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	52 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	5,000	5,000	5,000
Lifetime Maximum Benefit	10,000	10,000	10,000

LIMITS OF LIABILITY

OCCUPATIONAL COVERAGE:			
Combined Single Limit	$1,000,000	$500,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	2,000,000	1,000,000	600,000
NON-OCCUPATIONAL COVERAGE:			
Combined Single Limit	$ 15,000	$ 15,000	$ 15,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	30,000	30,000	30,000

MONTHLY RATE PER DRIVER**:** **PLAN 1**: $146.00 **PLAN 2**: $136.00 **PLAN 3**: $125.00

PASSENGER ACCIDENT BENEFITS

ACCIDENTAL DEATH	
Principal Sum	$ 100,000
Accident Commencement Period	365 days
ACCIDENTAL DISMEMBERMENT	
% of Principal Sum of	$ 100,000
Paralysis Benefit	$ 100,000
Accident Commencement Period	365 days
ACCIDENT MEDICAL EXPENSE	
Medical Commencement Period	90 days
Deductible Amount	$ 50
Maximum Benefit Period	52 weeks
Dental Maximum per Accident	$ 1,000
Maximum Benefit Amt per Accident	$ 100,000
Lifetime Maximum Benefit	$ 100,000

LIMITS OF LIABILITY

PASSENGER ACCIDENT COVERAGE	
Combined Single Limit	$ 100,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$ 200,000

MONTHLY RATE PER DRIVER FOR **PASSENGER ACCIDENT COVERAGE**: $10.00

SERFF Tracking Number:	*CLTR-127649230*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49895*
Company Tracking Number:	*AH 422A OAICT AR*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Occupational Accident*		
Project Name/Number:	*Occupational Accident ICT/AH 422A OAICT*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/04/2011

Comments:

Attachment:

ASIC ICT CW Readability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/04/2011

Comments:

Attachments:

ASIC 428AA Arkansas Independent Contractor Trust Enrollment Form Plans A B C.pdf

ASIC 429AA Arkansas Independent Contractor Trust Enrollment Form Plans 1 2 3.pdf

		Item Status:	Status Date:
Satisfied - Item:	Authorization to File	Approved-Closed	10/04/2011

Comments:

Attachment:

ASIC Authorization to File.pdf

		Item Status:	Status Date:
Satisfied - Item:	Certification Rule 19	Approved-Closed	10/04/2011

Comments:

Attachment:

Rule and Regulation 19 Certification.pdf

READABILITY CERTIFICATION

This is to certify that the form(s) below has (have) been subject to the Flesch Reading Ease Test.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

__X__ 2. Policy and riders are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

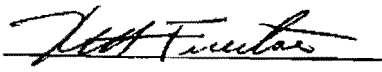
Form	Form Number	Flesch
Certificate of Insurance	AH-422A OAICT 08 11	40.7
Enrollment & Beneficiary Designation Form	AH 428AA OAICT 08 11	46.8
Enrollment & Beneficiary Designation Form	AH 429AA OAICT 08 11	44.9

B. Test Option Selected

__X__ 1. Test was applied to entire form(s).

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms enclosed indicating word samples tested.

Company Name: Atlantic Specialty Insurance Company

Signature of Certifying Official: 

Printed Name and Title of Certifying Official: Keith Firestone, Assistant Secretary

Certifying Official's Address: 1 Beacon Lane, Canton MA 02021-1030

Date Signed: September 26, 2011

OneBeacon INSURANCE

Independent Contractor Trust

OCCUPATIONAL ACCIDENT
ENROLLMENT AND BENEFICIARY DESIGNATION FORM

This form must be complete, signed and dated before it can be processed and coverage can be put into effect.

Please indicate which Plan you are enrolling in: **Plan A** ☐ **Plan B** ☐ **Plan C** ☐

Do you wish to purchase coverage for your Authorized Passengers? **Yes** ☐ **No** ☐

Individual Driver Information: (please print)

Name[/Member #]: _____

Address: _____

City: _____

State: _____ Zip: _____

Social Security Number: _____

Date of Birth: _____

Home Telephone Number: _____

Cell Phone Number: _____

E-mail Address: _____

Beneficiary: _____

Relationship to Beneficiary: _____

Address of Beneficiary: _____

_____

ICC Number: _____

CDL Number: _____

Number of Years Experience: _____

Contracted By (Name of Company): _____

_____

Address: _____

City: _____

State: _____ Zip: _____

Effective Date of Contract: _____

Motor Carrier Phone Number: _____

Motor Carrier Fax Number: _____

Motor Carrier E-mail Address: _____

_____

General Information:

Are you an Owner/Operator: a) with your own authority? Yes ☐ No ☐ b) leased to a Motor Carrier? Yes ☐ No ☐

If no to both of the above, are you a: Co-Driver ☐ Contract Driver ☐ (and you receive a Form 1099) Employee Driver ☐ (and you receive a Form W-2)

Are you a team driver? Yes ☐ No ☐

Trailer type used? Dry Van ☐ Refer ☐ Box ☐ Flat Bed ☐ Dump ☐ Other_____

Years of experience hauling the above type trailer? _____

Do you haul any Oversize or Overweight loads, or pull any double trailers? Yes ☐ No ☐ If so, which?_____

Type of Carriage? Truck Load ☐ LTL ☐

Do you load/unload? Yes ☐ No ☐

If yes, what is the average weight you lift? _____

Do you attach and detach the trailer? Yes ☐ No ☐

Do you tarp? Yes ☐ No ☐ Do you strap? Yes ☐ No ☐

What do you haul? _____

What other duties do you perform? _____

Are you covered under any medical plan? Yes ☐ No ☐

If yes, please provide name of carrier: _____

I hereby authorize the Program Administrator to bill the following selected party for my Occupational Accident coverage:

☐ Self ☐ Motor Carrier, as listed on the front of this Form

☐ Other: _____

Name

_____

Street/PO Box

_____

City State Zip

I understand that the cost of the insurance is my sole obligation and responsibility. I agree that I will forward any amount due to the Program Administrator upon demand, for any insurance at any time my account remains unpaid.

I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier above nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to Atlantic Specialty Insurance Company, or the Program Administrator or its designated representative. A photographic copy of this authorization shall be as valid as the original.
4. I am 18 years of age or older and I am under dispatch an average of 30 hours each week.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee. Or I am an employee, and I receive a W-2 form, but I am exempt from Workers' Compensation insurance; I understand that my employer and I must sign a certificate of exemption form to substantiate this.

PARTICIPATION IN TRUST

I understand and acknowledge that by enrolling for insurance coverage I will become a Participant in the Independent Contractor Trust and that I must abide by the terms and conditions of the Trust. A copy of the Trust Agreement will be provided at the Enrollee's request. Please write to: Atlantic Specialty Insurance Company at 1000 Woodbury Road, Woodbury, NY 11797, Attn: John Ruvolo.

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

IF THE INFORMATION YOU HAVE PROVIDED IS FRAUDULENT,
WE MAY HAVE THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information you have provided, you are giving us authority to examine the records that are maintained by the motor carrier and the Program Administrator.

Enrollee's Signature: _____ **Date:** _____

Agent/Producer Signature: _____ **Date:** _____

Agent/Producer Code (if known): _____

Note: The information below is only a brief description of the coverage provided under this group program. Refer to the Policy which provides the contract of insurance for a description of benefits, limitations and exclusions.

OCCUPATIONAL ACCIDENT BENEFITS	A	B	C
ACCIDENTAL DEATH			
Principal Sum	$ 50,000	$ 25,000	$ 25,000
Survivor's Benefit	200,000	125,000	125,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$250,000	$150,000	$150,000
Monthly Benefit	2,000	1,250	1,250
Paralysis Benefit	250,000	150,000	150,000
Accident Commencement Period	365 days	365 days	365 days
TEMPORARY TOTAL DISABILITY			
Disability Commencement Period	90 days	90 days	90 days
Waiting Period	7 days	7 days	7 days
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Period	104 wks	52 wks	52 wks
CONTINUOUS TOTAL DISABILITY			
Waiting Period	104 wks	52 wks	52 wks
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Amount	400,000	300,000	200,000
Maximum Benefit Period	to age 70	to age 70	to age 70
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	104 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	1,000,000	500,000	300,000
Lifetime Maximum Benefit	1,000,000	500,000	300,000

NON-OCCUPATIONAL ACCIDENT BENEFITS	A	B	C
ACCIDENTAL DEATH			
Principal Sum	$ 10,000	$ 10,000	$ 10,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$ 10,000	$ 10,000	$ 10,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	52 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	5,000	5,000	5,000
Lifetime Maximum Benefit	10,000	10,000	10,000

LIMITS OF LIABILITY

OCCUPATIONAL COVERAGE:			
Combined Single Limit	$1,000,000	$500,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	2,000,000	1,000,000	600,000
NON-OCCUPATIONAL COVERAGE:			
Combined Single Limit	$ 10,000	$ 10,000	$ 10,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	20,000	20,000	20,000

MONTHLY RATE PER DRIVER**:** **PLAN A**: $136.00 **PLAN B**: $126.00 **PLAN C**: $118.00

PASSENGER ACCIDENT BENEFITS

ACCIDENTAL DEATH	
Principal Sum	$ 100,000
Accident Commencement Period	365 days
ACCIDENTAL DISMEMBERMENT	
% of Principal Sum of	$ 100,000
Paralysis Benefit	$ 100,000
Accident Commencement Period	365 days
ACCIDENT MEDICAL EXPENSE	
Medical Commencement Period	90 days
Deductible Amount	$ 50
Maximum Benefit Period	52 weeks
Dental Maximum per Accident	$ 1,000
Maximum Benefit Amt per Accident	$ 100,000
Lifetime Maximum Benefit	$ 100,000

LIMITS OF LIABILITY

PASSENGER ACCIDENT COVERAGE	
Combined Single Limit	$ 100,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$ 200,000

MONTHLY RATE PER DRIVER FOR **PASSENGER ACCIDENT COVERAGE**: $10.00

OneBeacon INSURANCE

Independent Contractor Trust

OCCUPATIONAL ACCIDENT
ENROLLMENT AND BENEFICIARY DESIGNATION FORM

This form must be complete, signed and dated before it can be processed and coverage can be put into effect.

Please indicate which Plan you are enrolling in: **Plan 1** ☐ **Plan 2** ☐ **Plan 3** ☐
Do you wish to purchase coverage for your Authorized Passengers? **Yes** ☐ **No** ☐

Individual Driver Information: (please print)

Name[/Member #]: _____
Address: _____
City: _____
State: _____ Zip: _____
Social Security Number: _____
Date of Birth: _____
Home Telephone Number: _____
Cell Phone Number: _____
E-mail Address: _____
Beneficiary: _____
Relationship to Beneficiary: _____
Address of Beneficiary: _____
_____

ICC Number: _____
CDL Number: _____
Number of Years Experience: _____
Contracted By (Name of Company): _____
_____
Address: _____
City: _____
State: _____ Zip: _____
Effective Date of Contract: _____
Motor Carrier Phone Number: _____
Motor Carrier Fax Number: _____
Motor Carrier E-mail Address: _____
_____

General Information:

Are you an Owner/Operator: a) with your own authority? Yes ☐ No ☐ b) leased to a Motor Carrier? Yes ☐ No ☐
If no to both of the above, are you a: Co-Driver ☐ Contract Driver ☐ (and you receive a Form 1099) Employee Driver ☐ (and you receive a Form W-2)

Are you a team driver? Yes ☐ No ☐

Trailer type used? Dry Van ☐ Refer ☐ Box ☐ Flat Bed ☐ Dump ☐ Other_____

Years of experience hauling the above type trailer? _____

Do you haul any Oversize or Overweight loads, or pull any double trailers? Yes ☐ No ☐ If so, which?_____

Type of Carriage? Truck Load ☐ LTL ☐

Do you load/unload? Yes ☐ No ☐
If yes, what is the average weight you lift? _____

Do you attach and detach the trailer? Yes ☐ No ☐

Do you tarp? Yes ☐ No ☐ Do you strap? Yes ☐ No ☐

What do you haul? _____

What other duties do you perform? _____

Are you covered under any medical plan? Yes ☐ No ☐

If yes, please provide name of carrier: _____

I hereby authorize the Program Administrator to bill the following selected party for my Occupational Accident coverage:

☐ Self ☐ Motor Carrier, as listed on the front of this Form

☐ Other: _____
Name

_____
Street/PO Box

_____
City State Zip

I understand that the cost of the insurance is my sole obligation and responsibility. I agree that I will forward any amount due to the Program Administrator upon demand, for any insurance at any time my account remains unpaid.

I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Workers' Compensation Insurance and neither the carrier above nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to Atlantic Specialty Insurance Company, or the Program Administrator or its designated representative. A photographic copy of this authorization shall be as valid as the original.
4. I am 18 years of age or older and I am under dispatch an average of 30 hours each week.
5. I am an independent contractor and receive a 1099 tax form, not a W-2 tax form for an employee. Or I am an employee, and I receive a W-2 form, but I am exempt from Workers' Compensation insurance; I understand that my employer and I must sign a certificate of exemption form to substantiate this.

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WE MAY HAVE THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information you have provided, you are giving us authority to examine the records that are maintained by the motor carrier and the Program Administrator.

Enrollee's Signature: _____ **Date:** _____

Agent/Producer Signature: _____ **Date:** _____

Agent/Producer Code (if known): _____

Note: The information below is only a brief description of the coverage provided under this group program. Refer to the Policy which provides the contract of insurance for a description of benefits, limitations and exclusions.

OCCUPATIONAL ACCIDENT BENEFITS	**1**	**2**	**3**
ACCIDENTAL DEATH			
Principal Sum	$ 50,000	$ 25,000	$ 25,000
Survivor's Benefit	200,000	125,000	125,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$250,000	$150,000	$150,000
Monthly Benefit	2,000	1,250	1,250
Paralysis Benefit	250,000	150,000	150,000
Accident Commencement Period	365 days	365 days	365 days
TEMPORARY TOTAL DISABILITY			
Disability Commencement Period	90 days	90 days	90 days
Waiting Period	7 days	7 days	7 days
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Period	104 wks	52 wks	52 wks
CONTINUOUS TOTAL DISABILITY			
Waiting Period	104 wks	52 wks	52 wks
Benefit Percentage	70%	70%	70%
Maximum Weekly Benefit Amount	$ 500	$ 400	$ 400
Maximum Benefit Amount	400,000	300,000	200,000
Maximum Benefit Period	to age 70	to age 70	to age 70
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	104 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	1,000,000	500,000	300,000
Lifetime Maximum Benefit	1,000,000	500,000	300,000

NON-OCCUPATIONAL ACCIDENT BENEFITS	**1**	**2**	**3**
ACCIDENTAL DEATH			
Principal Sum	$ 15,000	$ 15,000	$ 15,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENTAL DISMEMBERMENT			
% of Principal Sum of	$ 15,000	$ 15,000	$ 15,000
Accident Commencement Period	365 days	365 days	365 days
ACCIDENT MEDICAL EXPENSE			
Medical Commencement Period	90 days	90 days	90 days
Deductible Amount	$ 0	$ 0	$ 0
Maximum Benefit Period	52 wks	52 wks	52 wks
Dental Maximum per Accident	$ 1,000	$ 1,000	$ 1,000
Maximum Benefit Amt per Accident	5,000	5,000	5,000
Lifetime Maximum Benefit	10,000	10,000	10,000

LIMITS OF LIABILITY

OCCUPATIONAL COVERAGE:			
Combined Single Limit	$1,000,000	$500,000	$300,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	2,000,000	1,000,000	600,000
NON-OCCUPATIONAL COVERAGE:			
Combined Single Limit	$ 15,000	$ 15,000	$ 15,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	30,000	30,000	30,000

MONTHLY RATE PER DRIVER**:** **PLAN 1**: $146.00 **PLAN 2**: $136.00 **PLAN 3**: $125.00

PASSENGER ACCIDENT BENEFITS

ACCIDENTAL DEATH	
Principal Sum	$ 100,000
Accident Commencement Period	365 days
ACCIDENTAL DISMEMBERMENT	
% of Principal Sum of	$ 100,000
Paralysis Benefit	$ 100,000
Accident Commencement Period	365 days
ACCIDENT MEDICAL EXPENSE	
Medical Commencement Period	90 days
Deductible Amount	$ 50
Maximum Benefit Period	52 weeks
Dental Maximum per Accident	$ 1,000
Maximum Benefit Amt per Accident	$ 100,000
Lifetime Maximum Benefit	$ 100,000

LIMITS OF LIABILITY

PASSENGER ACCIDENT COVERAGE	
Combined Single Limit	$ 100,000
Aggregate Limit of Liability (applicable to all covered losses with respect to any one accident)	$ 200,000

MONTHLY RATE PER DRIVER FOR **PASSENGER ACCIDENT COVERAGE**: $10.00

OneBeacon
INSURANCE

Date: August 23, 2011

To: State Insurance Departments

From: Dennis R. Smith

Subject: Filing Authority for Coulter & Associates, Inc.

I, Dennis Smith, an officer of Atlantic Specialty Insurance Company, have authorized Coulter & Associates, Inc., acting as our Contracts Consultants, to file products and correspond with your Department on our behalf.

This Authorization is effective until August 31, 2012.

Officer Signature: 

Title: Secretary

TO: Commissioner of Insurance
Arkansas Insurance Department

RE: Atlantic Specialty Insurance Company

RULE AND REGULATION 19 CERTIFICATION

This is to certify that the referenced certificate of coverage form complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed for Atlantic Specialty Insurance Company by

9/6/2011
Date

Signature

Keith Firestone, Assistant Secretary
Typed Name and Title